Kearney
Clinic, P.C.

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Kearney, NE 68845
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FAX (308)865-2150

Family Practice
B.M. Ernst, M.D.
D.A. Sokolowski, M.D.
T.L. Potthoff, M.D.
D.M. Murray, M.D.
T.A. Becker, M.D.
C.S. Murray, M.D.
R.L. Goldfish, M.D.
B.A. Bohn, M.D. F.A.A.F.P.
K.H. Boos, M.D.
D.R. Sughroue, FNP-C
J.M. Murray, FNP-C
A.N. Rabe, WHNP-BC
H. D. Kaestner, FNP-C

General Surgery
W.T. Sorrell, M.D.
J.T. Merz, M.D.
B.J. O'Hare, M.D.
K.D. Koster, PA-C

Pediatrics
K.A. Keifer, M.D.
D.K. Psota, M.D.
M. C. Howe, M.D.
S.C. Haskett, M.D.
A.J. Kratochvil-Stava, M.D.
A.D. Casper, M.D.
M.M. Saathoff, M.D.
M.A. Caha, DO

Quick Care
L.K. Verzal, PA-C
E.P. Barnes, PA-C

Clinical Psychology
M. C. Renner, Ph.D.

Mental Health
E.M. Nickel-Drabek, LIMHP

Administrator
Peggy K. Dobish

Advance Authorization for Treatment of a Minor

For families who are ongoing patients of Kearney Clinic:

It may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize Kearney Clinic, and its personnel to deliver medical care to my child listed below:

PLEASE PRINT

Name:_____

DOB:_____

Chart Number:_____

Please try to contact me (us) regarding health care of my child at the following phone number(s):

Parent's name:_____

Phone(office/home):_____

Parents name:_____

Phone (office/home):_____

Other (Guardian/Case Worker):_____

Phone (office/home): _____

Signature:_____

Date:_____